COVID-19 Vaccination Registration Form

Instructions: Complete the patient information and screening sections below and return this form to the vaccinator prior to receiving your shot. Please print all information clearly and accurately and ensure your name is also printed on page two.

PATIENT INFORMATION

Name (Last, First): ____________________

Date of Birth (DOB): ____________________

Primary Residential Address: ____________________

Street *City* *State* *ZIP*

Phone Number (where we can best reach you): ____________________

Email Address: ____________________

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Prefer not to answer

Race (select one):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White ☐ Prefer not to answer ☐ Other Race

Are you Hispanic or Latino? (Select one):

☐ Yes ☐ No ☐ Prefer not to answer

Do you have insurance? If yes, please fill out the information below.

☐ Yes ☐ No

INSURANCE CARRIER: ____________ POLICY #: ____________ GROUP #: ____________

PRE-SCREENING:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 Vaccine? If yes, which vaccine product? ☐ Moderna ☐ Pfizer ☐ Janssen (Johnson & Johnson)			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
• A component of a COVID-19 vaccine such as polyethylene glycol (PEG) found in some medications like laxatives or polysorbate found in some vaccines, film coated tablets, and intravenous steroids?			
4. Do you have a bleeding disorder or are you taking a blood thinner?			
5. Have you received passive antibody therapy as treatment for COVID-19?			
6. Have you received a positive test result for COVID-19 in the last 10 days? Have you been in close contact with someone who tested positive in the last 14 days?			
7. Have you received a vaccine or other injectable in the past 14 days?			

I certify that I am: (a) the patient and at least 18 years of age; or (b) authorized to consent for vaccination for the patient named above if under the age of 18. Further, I hereby voluntarily give my consent to the Cumberland County Department of Health or its agents to administer the COVID-19 vaccine. I understand that these products have been either been approved/licensed by FDA or authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization/Fact Sheets on the COVID-19 vaccine I have elected to receive, including the ages for which each vaccine is approved. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction after leaving the vaccination site, I will seek medical attention as needed. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Cumberland County Department of Health and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

I acknowledge that: (a) I understand the purposes/benefits of the immunization registry and (b) will include my personal immunization information in and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other appropriate state or federal agencies. I acknowledge receipt of the Notice of Privacy Rights.

____ ______________________________

Signature of Patient or Authorized Representative **Print Name of Patient**

____ ______________________________

Print Name of Representative and Relationship to Person Receiving Vaccine **Date**

OFFICIAL USE ONLY

Vaccine Manufacturer: Moderna 0.5mL ☐ Moderna 0.25mL ☐ Pfizer 0.3mL ☐ Pfizer 0.2mL ☐ Janssen 0.5mL ☐

Dose: First ☐ Second ☐ Third ☐ Booster ☐

If first dose, date & time second dose scheduled: ____________________________

Route of Administration: Intramuscular ☐

Vaccination Site: Left Deltoid ☐ Right Deltoid ☐ Left Anterolateral Thigh ☐ Right Anterolateral Thigh ☐

Vaccine Lot Number: ______________________ Vaccine Expiration Date: ______________________

Vaccine Administered by (please print): ____

Facility Name/Location: ____

Signature: ____

Date and Time: ____

Other Notes: ____